



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR BARRET BROWN
7401 SOUTH MAIN STREET
HOUSTON TX 77030-4509

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-12-0066-01

MFDR Date Received

SEPTEMBER 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "claim is not paid according to correct locality"

Amount in Dispute: \$10.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated September 9, 2011: "We have escalated the bill for additional review and it remains in process at this time."

Respondent's Position Summary dated October 4, 2011: "no additional money due."

Responses Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2011	CPT Code 29105-58-RT	\$5.87	\$5.87
April 6, 2011	CPT Code 73070-RT	\$2.10	\$2.10
April 20, 2011	CPT Code 73070-RT	\$2.10	\$2.10
TOTAL		\$10.07	\$10.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers'

compensation professional medical services provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W1-This charge was reimbursed in accordance to the Texas medical fee guideline.
- B13-Re-evaluated; no additional payment is recommended.

Issues

1. Is the requestor entitled to additional reimbursement for CPT Code 29105?
2. Is the requestor entitled to additional reimbursement for CPT Code 73070?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203 (b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

CPT code 29105 is defined as "Application of long arm splint (shoulder to hand)."

The 2011 DWC Conversion factor is \$54.54.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77494, which is located in Harris County.

The MAR for CPT code 29105 in Harris County is \$134.02. The respondent paid \$128.15; therefore, the requestor is due the difference between the MAR and amount paid of \$5.87.

2. CPT Code 73070 is defined as "Radiologic examination, elbow; 2 views."

The MAR for CPT code 73070 in Harris County is \$45.76. The respondent paid \$43.66; therefore, the requestor is due the difference between the MAR and amount paid of \$2.10.

The requestor billed CPT code 73070 for two dates; therefore, \$2.10 multiplied by 2 dates equals \$4.20.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$10.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$10.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

05/09/2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.